Instructions for Applying for Services

If you are interested in applying for services from the Division of Developmental Disabilities Services (DDDS), the attached forms will need to be printed out & completed. Please note that **the applicant if they are over age 18 and/or their legal guardian, if appropriate, must sign ALL forms.** If the applicant is unable to sign their name, they make a mark on the signature line and have it witnessed by a friend or family member.

Completed forms need to be sent to

Dorphine Abrams
Office of the Director
Division of Developmental Disabilities Services
Woodbrook Professional Center
1056 South Governor's Avenue, Suite 101
Dover, DE 19904
(302) 744-9600

In addition, the Division **requires** that all applications **MUST** be accompanied with a photocopy of the applicant's Birth Certificate, Social Security Card, Medicare and/or Medicaid Card and/or Private Health Insurance Card. Photocopies of Guardianship papers, Immigration/visa papers are also required, if applicable. Without these documents, your application will be considered incomplete and we will not be able to initiate the application process.

Following the receipt of an application, the DDDS will send for copies of records that are important for establishing an applicant's eligibility for services. Please be advised that it may take up to four months to complete the application process; however, if the applicant is able to submit copies of records with the application, the amount of time could be greatly reduced. In some cases, it may be necessary to schedule the applicant for a psychological evaluation with the Division's psychologist. If further testing does become necessary you will be contacted by phone regarding the process for the testing.

If you need any help or have any questions regarding these forms or the Intake process, please do not hesitate to call for assistance at the Division of Developmental Disabilities main office.

STATE OF DELAWARE
DEPARTMENT HEALTH & SOCIAL SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES

APPLICATION FOR SERVICES

1. Name of Applicant:_____ Birth date:_____

2. Address:_____
Street *City* *County* *State/Zip*

3. Social Security Number:_____ Medicaid* Number:_____

Medicare Number:_____ Other Medical Insurance (Name and Number):_____

* Note: Medicaid furnishes medical assistance to eligible low-income families and to eligible aged, blind and/or disabled people whose income is insufficient to meet the cost of necessary medical services. If you do not currently receive Medicaid, you may apply at your local State Service Center. Information may be obtained by calling 1-800-372-2022.

4. Is applicant a resident of Delaware? ☐ Yes ☐ No

5. Is applicant a citizen of the United States? ☐ Yes ☐ No

If no, please indicate your legal status
- ☐ United States Citizen (born in the United States)
- ☐ United States Citizen (born outside the US)
- ☐ Lawful Immigrant (**copies of documentation must be supplied**)
- ☐ Alien (country in which you were born)_____

6. Copies of the following documents are required (***please check the square of each item you have included***):

- ☐ Birth Certificate
- ☐ Medicaid/Medicare Card
- ☐ Guardianship Papers (*if applicable*)
- ☐ Social Security Card
- ☐ Private Health Insurance Card

7. Parent/Court Appointed Guardian:_____

If Guardian, please check Guardian of Person ☐ Guardian of Property ☐ Both ☐

8. Address:_____
Street *City* *State/Zip*

9. Required Signatures:

_____ _____
Applicant (if applicable) *Date*

_____ _____ _____
(Parent, Court Appointed Guardian, Relative, Personal Advocate) *Date* *Relationship to Applicant*

_____ _____ _____
Witness *Date* *Number where you can be reached if necessary*

POLICY OF THE STATE OF DELAWARE AS ESTABLISHED BY STATE LAW AND EXECUTIVE ORDER ASSURES EQUAL OPPORTUNITY AND PROHIBITS DISCRIMINATION ON THE BASIS OF RACE, RELIGION, COLOR, ORIGINAL ORIGIN, SEX OR AGE.

YOUR INDIVIDUAL PROFILE

1. INFORMATION ABOUT YOU (the person applying for DDDS services**)**

Name:_____ Birthdate: _____

Sex (*Male / Female*):_____ Phone No.:_____

Your primary Caretaker if other than yourself:

Name: _____

Address: _____

Phone Number: _____ Relationship to you: _____

Race/Ethnicity: _____ White/Caucasian _____ Oriental/Vietnamese

_____ Black/African American _____ American Indian

_____ Spanish Origin _____ Other (Specify) _____

Religious Preference: _____ Christian _____ Jewish

_____ Muslim _____Buddhist

_____ Hindu _____ Other (Specify) _____

INFORMATION ABOUT YOUR FAMILY

Name of Mother:_____

Birth date & Social Security # of Mother:_____

Name of Father:_____

Birth date & Social Security # of Father:_____

Do you have a genetic disorder? ☐ No ☐ Yes (*please describe*) _____

Did any of the following problems or conditions exist during your mother's pregnancy:

☐ Bleeding ☐ Infections ☐ Diseases ☐ X-Ray Exams

☐ Shock ☐ Drug Use ☐ Falls ☐ Strain (physical, mental, emotional)

Please describe anything you have checked _____

_____

2. ABOUT YOUR BIRTH

Were there any difficulties with your birth? ☐ No ☐ Yes

If yes, please explain _____

_____

Were you: ☐ Full term ☐ Premature (how many months were you when born?) _____

Was anesthesia used during your birth? ☐ Yes ☐ No ☐ Not Sure

Were instruments used? ☐ Yes ☐ No ☐ Not Sure

Did you cry at once? ☐ Yes ☐ No ☐ Not Sure

Were you jaundiced (yellow) at birth or soon after? ☐ Yes ☐ No ☐ Not Sure

If yes, for how long? _____

Did you require special treatment to help with breathing? (injections, oxygen, etc.)

☐ Yes ☐ No ☐ Not Sure

What was your weight at birth? _____

3. ABOUT YOUR DEVELOPMENT

Did you ever receive early childhood intervention services? ☐ Yes ☐ No

Please tell us how old you were when the following Developmental Milestones happened for you:

Teething _____ Sitting Alone _____ Standing Alone _____

Walking Alone _____ Beginning to Talk _____ Toilet Trained _____

4. SCHOOL HISTORY

What school do you go to?

Name _____ Phone: _____

Address: _____

_____

If you don't go to school now, where did you last go to school?

Name: _____ Phone: _____

Address: _____

_____

Last Grade attended: _____

Age and dates attended: _____

Were you a Special Education student? ☐ Yes ☐ No

Did you receive a Certificate of Attendance? ☐ Yes ☐ No If yes, what year? _____

Did you receive a diploma? ☐ Yes ☐ No If yes, what year? _____

Have you ever attended a day program? ☐ Yes ☐ No

If yes, what is the name of the program and when did you attend? _____

_____

5. TEST HISTORY

Date of your last psychological test? _____

Who tested you, and where? _____

6. WORK HISTORY

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Where Have You Worked?	What Type of Work Did You Do?	When Did You Work There? (Dates)

7. SERVICE HISTORY: Do you or have you received services from any of the following **(please check all that apply)**

	Current	**Past**
A.I. DuPont Institute	☐	☐
Child Development Watch	☐	☐
Division of Child Mental Health	☐	☐
Delaware Autistic Program	☐	☐
Delaware Psychiatric Hospital	☐	☐
Division of Family Services	☐	☐
DDDS (Respite-Residential)	☐	☐
Governor Bacon	☐	☐
Elwyn	☐	☐
Kent-Sussex Industries	☐	☐
Meadowood Hospital	☐	☐
Mental Hygiene Clinic/Mental Health Center Location:	☐	☐
Rockford Center	☐	☐
Stockley Center	☐	☐
Terry Center	☐	☐
Vocational Rehabilitation	☐	☐
Other:	☐	☐

8. CRIMINAL HISTORY

Have you ever been convicted of a criminal offense *(Felony or Class A Misdemeanor)?* ☐ Yes ☐ No
If yes, tell us the type of offense, date & location: _____

_____

Are you currently on probation or parole? ☐ Yes ☐ No

Comment, if yes: _____

_____

Name and phone number of probation officer: _____

_____

9. PSYCHIATRIC HISTORY

Have you ever received out-patient psychiatric treatment? ☐ Yes ☐ No

Name and address of physician _____

_____

Dates of Treatment: _____

Have you ever received in-patient psychiatric treatment? ☐ Yes ☐ No

Name and address of facility _____

_____

Dates of Treatment: _____

10. CURRENT MEDICATIONS

Please tell us about all the medicines you are taking. Please continue on back of next page if needed.

Medication: _____
Circle: Prescription or Non-Prescription
Reason Given: _____
How do you take it: _____

Medication: _____
Circle: Prescription or Non-Prescription
Reason Given: _____
How do you take it: _____

Medication: _____
Circle: Prescription or Non-Prescription
Reason Given: _____
How do you take it: _____

Person Helping You Complete This Profile: _____ Phone: _____

Person Providing the Information: _____ Phone: _____

Date Of Completion: _____

Required Signatures:

Signature of Individual Seeking Services _____

Signature of Guardian/Family Member (*if applicable*) _____

Revised 9/15/03

DELAWARE HEALTH AND SOCIAL SERVICES

CONFIDENTIALITY NOTICE TO CLIENTS

We want you to know why we need to collect information about you and your family, the steps we take to protect your privacy, and your rights to know what information we will keep in our records.

Please ask us for more details if you have any questions.

Why do we keep records? Delaware laws authorize the Department to collect and keep information we need to carry out our duties. This information is important for planning how to best work with you and your family.

Who else may learn this information? For the most part, only Department staff are permitted to know this information, unless you give us written permission to share it with someone else. If you are working with a team of people from different agencies within the Department, information may be shared among the team. The law requires us to share information in some other situations, such as court orders; emergencies threatening health or safety; and investigation of waste, abuse, or fraud.

Will Department staff keep this information confidential? All of our staff sign a confidentiality agreement, which clearly describes their duty to protect the privacy of all of our clients. In addition, the ethical codes of physicians, psychologists, nurses and social workers require them to keep information shared with them confidential.

Information shared with licensed physicians, psychologists and social workers cannot be subpoenaed, with the following exceptions: hospitalization proceedings: court ordered examinations; proceedings in which a guardian is sought, if the client's condition is part of the client's legal claim or defense; and alleged child/impaired adult abuse or neglect cases.

Where is information stored? When not in use, all written records about you are kept under lock. Some information about you may be stored on a computer system. We protect information stored in computers by "locking-out" all but the staff authorized to learn that information.

What are your rights? You have a right to find out what records we keep about you, how they will be used, and how they will be shared with others. You also have a right to review your records, except for certain confidential information and investigative files. If you object to or do not agree with the information in our records, you may ask us to change our records.

If we decide that we cannot change the records, you may give us your information in writing, and we will put it in the records.

What if you have other questions? Please ask the staff person working with you if you have any other questions. If you ask, we will give you a copy of our policy on confidentiality.

ADDENDUM

It may be necessary to speak with various agency personnel regarding your application and the records that we need in order to determine your eligibility for Division of Developmental Disabilities Services (DDDS). In addition, several other agencies sometimes have a need to know the status of your application and your eligibility for DDDS services. Below are listed those agencies with which we are in frequent contact. By checking the appropriate box you can let us know if you object to our discussing your application and eligibility for services. If approved, we will limit our exchange to information that is necessary in assisting you with services and will be kept in strictest confidence. This Authorization will remain in effect for one year from the date of signature.

	Approve	**Disapprove**
Personnel at the School(s) you attend(ed)	☐	☐
Voc Rehab Counselor	☐	☐
Division of Family Services/Child Mental Health	☐	☐
Health Care Provider	☐	☐
Arc Representative	☐	☐

I have read the information on this page and/or had it read to me and explained in a language I can understand. I understand my confidentiality rights.

_____ _____

(CLIENT/GUARDIAN SIGNATURE) (DATE Signed)

_____ _____

(DEPARTMENT EMPLOYEE/AGENT SIGNATURE) (DATE SIGNED)

DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES

AUTHORIZATION FOR RELEASE OF INFORMATION

Applicant: _____ D.O.B. _____ SS# _____

I, _____ hereby authorize the following agencies indicated below to release
Applicant/Guardian/Parent

and send information to The Division of Developmental Disabilities Services at Woodbrook Professional Center, 1056 South Governor's Avenue, Suite 101, Dover, Delaware 19904 or fax number (302) 744-9632.

A. I. DuPont Hospital for Children	Yes ____	No ____
Child Development Watch	Yes ____	No ____
Division of Child Mental Health	Yes ____	No ____
Division of Adult Mental Health	Yes ____	No ____
Division of Vocational Rehabilitation	Yes ____	No ____
Delaware Autistic Program	Yes ____	No ____
Delaware Psychiatric Center	Yes ____	No ____
Division of Family Services	Yes ____	No ____
Meadowood Hospital	Yes ____	No ____
Rockford Center	Yes ____	No ____
School _____	Yes ____	No ____
Terry Center	Yes ____	No ____
Other: _____	Yes ____	No ____

This release of information is for the purpose of determining an applicant's eligibility for DDDS services and to assist in planning for services.

The type of information to be released is not limited and is to specifically include any history (social, behavioral, developmental, psychiatric) medical evaluations, psychological testing, consultations and discharge summaries.

The dates of service to be covered by this authorization include all years of services received/admissions.

I understand that this authorization is valid for sixty (60) days from the date signed, and that I may revoke this authorization by written communication to the Director of the Division of Developmental Disabilities Services at the Woodbrook Professional Center, 1056 South Governor's Avenue, Dover, DE 19904.

Disclosure of specific information authorized for release is limited to the above-mentioned applicant only. Federal regulations 42 CFR Part 2 prohibits the redisclosure of information, unless the consent expressly permits further disclosure or is otherwise permitted under regulation.

_____ _____

Applicant Signature (if over age 18)/Guardian **Date**

_____ _____ _____

Parent/Guardian/Custodian *Date* *Relationship to Applicant*

This Authorization must be signed by the applicant (if over the age of 18) or their court appointed guardian. In the case of a minor, a parent or court appointed custodian must sign this Authorization.

8/1/04

DELAWARE HEALTH AND SOCIAL SERVICES

Division of Developmental Disabilities Services

FINANCIAL RESPONSIBILITY NOTICE

I understand that I may have some financial responsibility for the cost of services provided by the State of Delaware, Department of Health and Social Services, Division of Developmental Disabilities Services, as established by 29 Del. C §7940.

In order to determine any financial responsibility for the services I receive, I will be asked to disclose all information with regard to my financial status and assets including any jointly held financial accounts or accounts bearing my name.

The parents of a minor child receiving services may be asked to disclose their financial status and assets in order to determine any financial obligations and responsibilities they may have for the services provided to their child.

Financial resources received by the Division of Disabilities Services (DDDS) for an individual will be applied to the costs of the service(s) received in accordance with applicable Social Security, Medicaid and State rules and regulations.

Each individual receiving services has the responsibility of informing the DDDS of any changes in their financial status. Periodic updates of an individual's financial status and assets may be necessary during the receipt of services in order to assess the individual's financial responsibility and ensure continued eligibility for federal benefit programs.

Failure to fully disclose one's financial status and assets may result in a denial or loss of services.

I have read and understand the above notice and agree to assist the DDDS in determining any financial obligations I may have for services I receive.

_____ _____

Signature of Applicant Date

_____ _____

Signature of Parent (if applicant is a minor) or Substitute Decision-Maker /Legal Guardian (if applicable) Date

_____ _____

Witness Date